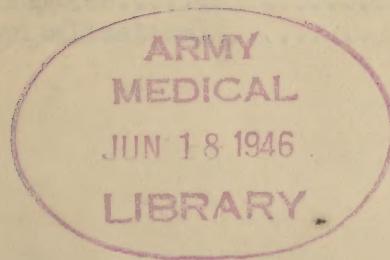


GENERAL HEADQUARTERS
UNITED STATES ARMY FORCES, PACIFIC
Office Of The Chief Surgeon



CONSOLIDATED CIRCULAR
CHIEF SURGEONS' OFFICE

1 JUNE 1946



GENERAL HEADQUARTERS
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CIRCULAR LETTER NO. 7

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APO 500
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CIRCULAR LETTER)

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PART I

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I. GENERAL

I. Rescission Of Circular Letters.

1. All Circular Letters published by the Chief Surgeon, United States Army Forces in the Far East and by the Chief Surgeon, United States Forces in the Pacific which were issued and signed by the Chief Surgeon thereof prior to this date, are hereby rescinded or superceded. All of the material in the above mentioned Circular Letters which is still applicable is published herein.

II. Announcement of New Policy In Publication Of Surgeons' Circulars.

2. This announces a new policy governing the publication of Circular Letters Chief Surgeons' Office, United States Army Forces, Pacific. Hereafter each month or more often if necessary, an informational circular will be issued by this office. This circular will be divided roughly into three parts as follows:

a. Part I - Administrative will be subdivided into paragraphs on General, Dental, Veterinary, Supply, Hospitalization and Evacuation, Personnel, Fiscal, Hospital Fund, Hospital Administration, and other similar subjects.

b. Part II - Technical will contain all articles of a medical professional nature including sanitary data on health conditions in specific areas.

c. Part III - Statistical will contain current tables on vital statistics, disease rates, bed authorization and bed occupancy tables, and evacuation rates. It may contain any other statistical data of a professional or administrative nature that may be of informational value to the field. Data on vital statistics and on other subjects when possible is to be presented graphically showing fluctuations over extended periods.

3. The initial issue and thereafter the first issue of each calendar year will consolidate all information or data that is still applicable and supersede all previous issues of Chief Surgeons' Circulars.

4. Extracts from the Essential Technical Medical Data Report made by this office and formerly circulated in the field will be published therein when the material is considered of general interest.

5. Articles of an informational nature or comments that may be of general interest to the Major Commands are solicited from all units, from all Commanding Officers of Medical Department units and the Surgeons of the Major Commands. However any article to be published in a current issue should be mailed so as to reach the Office of the Chief Surgeon not later than the twentieth of the preceding month.

B. DENTAL

III. Dental Reports and Records.

6. Monthly Report of Dental Service (WD AGO Form 8-98).

a. A monthly report of Dental Service, WD, AGO, Form 8-98, 8 August 1944, (Old WD, MD Form No. 57, 14 May 1942), which may be used until existing stocks are exhausted) is to be rendered before the fifth (5th) day of the next succeeding month by every military station or separate command where a Dental Office has been on duty during the month. This includes both staged and active units regardless of whether any dental work was accomplished or not. Sufficient copies are to be forwarded through appropriate medical channels so that the original only, reaches the office of the Surgeon of the major command concerned. The Dental Surgeon of each major command: AFWESPA, AFMIDPAC, FEAF, Sixth Army, Eighth Army, and XXIV Corps, compiles the above reports and each forwards a consolidated copy to the Dental Section, Office of the Chief Surgeon, General Headquarters, United States Army Forces, Pacific, APO 500, by the 20th of the succeeding month. Reports delinquent to that date are to be consolidated on WD, AGO Form 8-98 and forwarded as early as practicable, showing under paragraph 2, that it is the supplemental report for Calendar month of _____.

b. The Dental Surgeons of all units who are staged or stationed unassigned within a Base are to forward an information copy of Form WD, AGO 8-98 to the Base Surgeon's Office, of the Base concerned.

c. Attention is invited to AR 40-1010, par 2a, (13), which directs that: "Intermediate offices will promptly subject reports to critical examination and any omissions or errors noted will be recorded in an indorsement and the reports promptly forwarded to higher authority. Under no circumstances will reports be returned for correction."

d. The consolidated Form WD, AGO 8-98 as compiled by the Dental Surgeon of each major command (AFWESPA, AFMIDPAC, FEAF, Sixth Army, Eighth Army, and XXIV Corps) is to show the following information under paragraph 5A.

- (1) The total number of Dental Officers that were reported by each station as accomplishing dental treatment.
- (2) The total number of Dental Officers that were reported by each station as accomplishing no dental treatment.
- (3) The number of Dental Officers assigned to full time administrative duties (this will include Dental Officers on duty with supply depots).
- (4) The number of Dental Officers lost to the command during the month by evacuation or adjusted service rating scores.

7. Letter Report of Central (Base) Dental Laboratories.

a. This report is to be forwarded on or before the fifth (5th) of each month from every Base Dental Laboratory. Sufficient copies will be forwarded through appropriate medical channels so that the original and two carbon copies will be received by the Dental Surgeon of the major command concerned.

b. The Dental Surgeon of each major command is to forward to the Dental Section, this headquarters, the original and one carbon copy of each Letter Report of Central (Base) Laboratories. They will be forwarded as enclosures to the monthly consolidated WD, AGO Form 8-98.

8. Disposition of Record. All dental records are to be kept in the unit as part of the permanent records of that unit or hospital. Where a unit is to be inactivated or otherwise closed, and the dead records are to be stored, provisions of current procedures to be used in closing medical installations should be adhered to.

C. VETERINARY

IV. Report Of Veterinary Meat And Dairy Hygiene Inspection, WD AGO FORM 8-134.

9. Preparation of the Report. The following instructions and interpretations of Section V, AR 40-2150, are published for use as a guide by inspection units in preparing and submitting the Report of Veterinary Meat & Dairy Hygiene Inspection, WD, AGO Form 8-134 (Formerly MD Form 110). Interpretations of Section V, AR 40-2150, by column, as found on WD AGO Form 8-134.

a. Column (1) of the report should contain the unit designation and APO. When the APO of a unit is changed without change of station, the new APO should be entered in column (1), and a notation such as "Previous APO 100", should be entered just below column (1).

b. Entry of the data normally requested in column (3) is in violation of Section IV, USAFFE Circular No. 80, 26 September 1943. "Not

Required" will be entered in this space.

c. The designation of the class of inspection in column (4) will correspond with the class designations found in paragraph 22, a., (4), AR 40-2150. Example: "(5) Any Receipt Except Purchase".

d. The entries in column (6), (7), and (8) will be in whole pounds only, except in the case of Class 1 and 2 inspections. The conversion factors for eggs, ice cream, milk, etc., found in paragraph 22, a, (6) of AR 40-2150 will be used.

e. In the case of Class 5 inspections, column (9) should show the base, port, or APO of origin. The term "USA" "Australia", or "Phillipines", etc., are not adequate. "Base M", SFPOE", or "APO 73" are acceptable.

f. In the case of Class 6 inspections, column (9) should show the total poundage shipped to each destination.

g. When Class 9 inspections are reported, the necessity by paragraph 22, h, AR 40-2150. An entry such as: "2% inspection to determine condition is appropriate.

h. When government-owned foods are rejected on Class 5, 6, 7 or 9 inspections, the information requested in paragraph 22, a, (9), AR 40-2150 will be entered on the inclosure to the appropriate inspection sheet in the same form as the following example:

Code 104 Beef, corned, canned. Total rejected 10,000.

Armour and Co., Est. No. 129 rejected 2,500.

Inspection Stamp: V. C. 27, 12-12-44

Date packed: 11-28-44

Contract No: Not shown.

Causes of rejection: Swellers, 15%; Leakers, 10%.

Physical damage, 75%

Manner of disposal: Burned.

Illinois Packing Co., Est. No. rejected 7,500.

Inspection Stamp: V. C. 109, 10-10-44

Date packed: Illegible.

Contract No: QM-63724-j-GHMAK-59.

Cause of rejection: Swellers, 30%; Physical damage 70%.

Manner of Disposal: Burned.

Contributing causes to losses: Outside, uncovered storage, lack of dunnage, rough handling. Products were received in June and July 1945 in good condition.

Every effort should be made to secure the above information. In the event that it is impossible to secure all of the data, in each case a notation should be made giving the reason why, as "Illegible"; "Unknown"; or "Not Shown". In cases where rejections are in excess of 2%, the contributing causes, such as: prolonged storage as shown by the date of receipt; undesirable type of storage; poor condition on receipt; etc., should be shown as well as the direct causes. The percentage for the cause of rejection should

be estimated, as: Swellers, 10%; Leakers, 80%, Physical damage, 10%. Swellers and leakers caused by physically damaged cans should be reported as "Physical damage", and not as "Swellers", or "Leakers".

10. Instructions and Interpretations of Section V, AR 40-2150 by Class of Inspection.

a. Inasmuch as excess ships' stores obtained from WSA vessels are in a great many instances not government-owned but are actually the property of the company operating the ship, they should in this case receive a Class 4 inspection.

b. In instances where products are given a Class 5 inspection for other services, a report should be made on a separate Form 8-134 and the entry in column (4) of the report should state "Inspection for Civil Affairs" or other appropriate entry. (See paragraph 21, a, AR 40-2150).

c. When Quartermaster supplies are shipped to food dumps under control of these agencies (as in 3, b, above) they should be reported under Class 6 with an appropriate entry in column (9) or on the inclosure to Class 6. These entries need not indicate the address or location of such installations. "U. S. Navy--7,000", "U. S. Marine Corps--5,000", etc., constitute adequate entries.

d. In instances where Quartermaster supplies are inspected at the time of issue to the Navy, Marine Corps, or other governmental agencies, such inspections should be reported as Class 7.

e. Quartermaster food stocks will be inspected when issued to the Post Exchange, and will be reported on the Class 7 inspection sheet. Any subsequent inspection of Post Exchange stocks will be reported as Class 9.

f. The inspection of ice cream during manufacture by or for a Post Exchange should be reported on the Class 8 inspection sheet, and an appropriate entry, such as "Incident to manufacture", should be made in column (9). It is suggested that this policy be followed even though the Post Exchange obtains the ice cream mix or other ingredients from the Quartermaster.

g. The inspection of ice cream and reconstituted milk during manufacture by or for the Quartermaster should be reported on the Class 9 inspection sheet in instances where such items are manufactured from government-owned products. An appropriate entry (as in 3, f, above) should be made in column (9). The inspection made at the time of issue should be reported on the Class 7 inspection sheet.

11. General instructions to be followed in preparing the report.

a. It is desired that the inspection of fresh fruits, canned and dehydrated fruits, fresh vegetables, canned and dehydrated vegetables, and other foods of non-animal origin such as rice, flour, sugar, etc., be entered on WD, AGO Form 8-134. The authority for such inspections (AFPAC Reg. No. 50-10) should be stated under Remarks, column (14) of the last sheet of the assembled report. The figures obtained from all classes of inspection of foods of non-animal origin should be totaled and reported only once, and

then on the last sheet of the assembled report. Entries for foods of non-animal origin should not be made on any sheet other than the last sheet of the report.

b. When an initial report is submitted it should be headed "Initial Report", and a final report should be headed "Final Report". (See paragraph 20, AR 40-2150).

c. WD AGO Form 8-134 is addressed to the Surgeon General, U. S. Army. Therefore it is basic and should not be forwarded as an inclosure, but only by 1st indorsement of the report itself by the base or unit surgeon. (See paragraph 23, AR 40-2150).

d. Wrapper indorsements are not authorized by Army Regulations, and will not be used in forwarding this report nor in returning it for correction.

12. Processing of the Report. Stations under the administrative command of AFMIDPAC and AFWESPACE are to forward the report, to arrive in triplicate to the Surgeons of their respective major commands, where it will be processed and corrected as prescribed in paragraph 23, AR 40-2150. The Surgeon of the Major Command is to forward the report directly to the Surgeon General, Washington 25, DC, indicating the action taken by his office. An information copy of the report, with all indorsements is to be furnished to the Chief Surgeon, General Headquarters, AFMIDPAC, APO 500 by the major command. Stations not under the administrative command of AFMIDPAC or AFWESPACE are to forward the report through the Surgeons of their major commands to the Chief Surgeon, General Headquarters, AFMIDPAC, APO 500. Sufficient copies are to be forwarded so that the report reaches this office in duplicate.

D. SUPPLY

V. Baby Foods. Quantities of baby foods called for in requisitions recently submitted by major commands indicate an intent to provide such baby foods from medical supply sources for necessary care throughout infancy. Attention is invited to the fact that such baby foods obtained through medical supply channels are for use in hospitals only, repeat, only. Baby foods needed after discharge of the new born infant from the hospital must be obtained from other sources. Quantities requested in future requisitions for these items should reflect the above limitations in their use.

VI. Improper Use of Technical Medical Agents.

13. The attention of the Commanding Officers of all Medical Department Installations is invited to the Provisions of Section II, WD Circular 321, 1945 as amended by Section 7, WD Circular 264, 1945. These circulars require that no medicinal agent which has not first met certain conditions which are enumerated therein will be administered to patients under care of the Medical Department of the United States Army. It has been reported that certain Medical Officers in the field are using unapproved drugs in the treatment of military patients.

VII. Use of Vaccines After Expiration Date.

14. It has come to the attention of the Chief Surgeons' Office that some Medical Department officers have interpreted the provisions of Section VII, Circular No. 454, War Department, 1944 to apply to all vaccines and have been using vaccines of all types for six months after the expiration

date stamped on the package. The above cited reference applies only to lots of Typhus Vaccine, Army Service Forces Catalog MED-3, Item No. 1612800, which bear an expiration date in 1944 or 1945 and which can be used for six months after the expiration date. Typhus vaccine which bears an expiration date in 1946 is not to be used beyond the expiration date marked on the package. The use, or retention in stocks, of any other type vaccine beyond the expiration date is not warranted nor authorized.

E. HOSPITALIZATION AND EVACUATION

VIII. List of Japanese Hospitals Equipped For Care Of Occidentals.

15. The following is a list of those hospitals in Japan which are suitable to care for accidental civilians who are not authorized treatment in U. S. Army Medical Department Installations:

a. Matsuzawa Psychopathic Hospital 304, 4 chome, Matsubara-cho Setagaya-Ku, Tokyo.

b. Seibo International Catholic Hospital 2, chome, Shimoochiai Yodobashi-ku, Tokyo.

c. Ippan (former Yokohama General) Hospital Yokohama.

d. International Hospital, Shinahara, Kobo.

F. PERSONNEL

IX. Surplus Officers.

16. AFPAC radio ZX 37001, dated 15 May 1946, announced that the basis for declaration of Medical Department officers as surplus would be the longest total service since 16 September 1940. ASTP graduates will accrue eligibility for declaration as surplus on the basis of total months of active commissioned service, which does not include the period served in enlisted status as a student. Regular Army officers and officers who signed Category I and II statements will not accrue eligibility for declaration as surplus, but their oversea tour of duty will be in accordance with current directives. Irrespective of the above, any officer for whom there is no appropriate vacancy should be declared surplus.

17. The purpose of the announcement was to establish uniformity in all major subordinate commands and the plan parallels the emphasis on length of service that is apparent in War Department instructions.

18. Of those surplus officers who are not required within the theater, the ones with the longest oversea service will be the first to be returned to the Z.I.

X. Annual Review of Medical Corps Classifications.

19. The annual review of Medical Corps professional classification is extremely important at this time, since it is imperative that each officer

be utilized to the greatest extent of his professional talent.

20. Inability of the War Department to currently replace specialists as they become eligible for readjustment makes it necessary for each command to re-examine its professional resources. In one instance, on-the-job training and evaluation in a general hospital of D grade specialists permitted the selection of a few officers who were found competent to occupy positions calling for C grade medical officers.

21. Changes in professional classification will be expedited in GHQ, AFPAC, so as to facilitate professional planning in connection with readjustment regulations.

PART II

TECHNICAL

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XI. Dental Service In Fixed Hospitals.

22. Patients frequently are required to report for Class I and II dental treatment shortly after discharge from fixed hospitals. In order to prevent undue loss of man power days it is desired a dental survey be made in accordance with AR 40-1010 and AR 40-510 and changes thereto, on all patients as soon as practicable after admission to fixed hospitals. Those patients with defects, which in the opinion of the dental surgeon are apt to be the cause of loss of time from duty within the near future, will be remedied before the patient is discharged from the hospital, provided the correction of dental defects does not require the patient to be retained in hospital beyond the evacuation time and policies of the area in which the hospital is located.

XII. Heat Treating Of Gold Alloys Used In Dental Prostheses.

23. In the processes of manipulation and soldering the physical properties of Gold Alloys are always changed. In order to restore these properties, all gold alloys used in partial denture construction should be heat treated after final assembly and adjustment, prior to the addition of acrylic plastic. The following technique is recommended:

- a. Heat metal until a dull cherry red and plunge in a 50% solution of sulfuric acid.
- b. Neutralize in soda solution, wash in water and dry.
- c. Place in salt solution and hold for 20 minutes at 324° to 329° C.
- d. Wash salt solution from alloy with hot water.
- e. For heat treating Cast Gold Alloys hold for 20 minutes at 268° to 274° C. Otherwise follow above technique.

24. To heat treat by above method use the following items:

Support Stand	#4423000
Support Stand 4" Ring	4426000
Porcelain Crucible	4215000
Clamp Adjustable	4175000
Thermometer Chemical	4445000
Alcohol Lamp or	7832000
Acetylene Bunsen Burner	5022400
Sodium Nitrate	1405000
Potassium Nitrate	1371000

- a. Place porcelain crucible in 4" ring on support stand and adjust to proper height so flame from alcohol lamp or acetylene burner will not contact the bottom of crucible.
- b. Place equal parts of Sodium and Potassium Nitrate in porcelain crucible.
- c. Place burette clamp above 4" ring on support stand and fix thermometer in clamp so the tip of it will be in the bottom of the crucible.

XIII. Treatment Of Rabies.

25. It is recommended that all persons bitten by animals be treated with anti-rabies vaccine as follows:

a. The bites of dogs, cats, monkeys and other animal pets, if superficial and not extensive, should be cauterized with fuming nitric acid as soon as possible. The 14 day Semple Anti-rabies Vaccine Treatment should be started immediately in cases of bites on the face and neck. Treatment should be instituted only if clinical symptoms of rabies develop in the animal while it is in quarantine in the case of bites located elsewhere than the face and neck. Treatment should be given in all cases where the animal cannot be located.

b. Treatment should be intensified in cases of bites on the face and neck when several days have elapsed from the time of the bite until a positive diagnosis is made on the animal. Treatment should likewise be intensified in the case of bites on the extremities where 10 days have elapsed between the bite and the receipt of the report of diagnosis.

c. Intensified treatment should be given as follows: (One dose is equivalent to one vial of standard Semple Anti-rabic Vaccine).

1st day	2 doses, one - AM one - PM
2nd day	1 dose, AM
3rd day	2 doses, one - AM one - PM
4th day	1 dose, AM
5th day	2 doses, one - AM one - PM
6th day	1 dose

The treatment should be continued one dose per day until the complete course of injections has been administered.

d. Treatment need not be given in cases where 14 days or more have elapsed between the time of the bite and first manifestation or clinical symptoms in the animal. Treatment should be discontinued if the quarantined animal, after observation for a period of 14 days, has not developed clinical symptoms or rabies. In all cases every effort should be made to locate and quarantine the animal. Attempts to locate the animal should continue although treatment has been instituted.

e. The injections are not entirely without danger and the indiscriminate injection of rabies vaccine should be discouraged.

XIV. Prevention And Control Of Plague.

26. General-a. The return of prisoners of war from plague endemic areas to occupied territory, the repatriation of Japanese nationals, the movement of refugees within occupied areas and the extensive disruption of sanitary and housing facilities all act to make plague a disease worthy of major consideration in planning to protect the health of troops in this command. India and China are the worlds' important foci of the disease, but it is also found throughout southeastern Asia, in Java, and irregularly in other islands of the southwest Pacific.

b. Plague is transmitted from rat to rat and from rat to man by certain fleas. Infection may occur through rubbing into a bite flea feces that contain plague bacilli. It may result from the handling of infected rodents or tissue specimens obtained from them. Attendants caring for patients may contract the disease through contact with infective discharges from buboes or the respiratory tract. Technicians may be infected while examining diagnostic specimens.

27. Clinical Course. As a rule, the onset is sudden with high fever and extreme prostration, after an incubation period of 2 to 10 days. The severity of the disease is, however, variable, and mild unrecognized cases are dangerous sources of infection. In the typical case there is a marked tendency toward dehydration, with a rapid feeble pulse, and often mental clouding which may progress to delirium, convulsions, or coma. In fatal cases death usually takes place between the third and fifth day. When recovery occurs convalescence begins between the sixth and tenth days. Three clinical types are described but cases may show manifestations of all three, and it is probable that bacteremia is more common than the clinical picture of septicemia:

a. Bubonic. Characterized by enlargement, on second or third day, of lymph nodes draining the portal of entry. Pain may be severe. Buboes usually become soft and suppurate, the surrounding skin may become necrotic, with rupture of the bubo and discharge of a thin fluid.

b. Pneumonic. Characterized by cough, thin bloody sputum, dyspnoea and diffusely scattered rales.

c. Septicemic. Characterized by immediate prostration and the development of superficial blebs, petechiae, purpuric spots and hemorrhages from various parts of the body. There may be generalized lymphadenopathy.

28. Prior to the use of sulfonamide therapy the case fatality rate was 30% or more in the bubonic type. Recovery was unusual in pneumonic and rare in septicemic cases. In a recent series of patients with positive blood cultures, reported from India, reduction of the mortality rate from 90.6% to 20.9% was achieved by use of sulfadiazine.

29. Diagnosis. The specific diagnosis of plague is made by stained smear, culture, or animal inoculation of infectious material from sputum, aspirated tubo contents, or blood. (See TM 8-227) WARNING: ALL INFECTIOUS MATERIAL MUST BE HANDLED WITH THE GREATEST CARE.

30. Treatment. The patient must be put to bed immediately and strictly isolated. Good general medical and nursing care is essential. The total intake of fluids should be regulated to insure a daily urinary output of at

least 1,500 cc. If necessary, fluid should be administered by vein. It is most important to initiate treatment with a sulfonamide without delay after the diagnosis has been established. Sulfadiazine is the drug of choice. Sulfathiazole may be used. Therapy must aim at high blood levels of from 15 to 20 mg. per 100 cc, during the first four or five days of the disease. Whenever possible, blood level determinations should be made at regular intervals and the dosage adjusted to maintain high levels. The initial dose by mouth should be 4.0 gm (60 grains), subsequent doses 1.5 to 2.0 gm (22½ to 30 grains) every four hours day and night until temperature is normal. Then continue with 0.5 gm (7½ grains) every four hours for at least ten to fifteen days after the temperature is normal. A gradual reduction in the blood level to 10 to 15 mg. per 100 cc is indicated when the patient shows improvement. In fulminating cases or when treatment has been delayed, sodium sulfadiazine (5 percent solution in sterile distilled water) should be given intravenously: initial dose, 6 to 8 gm (90 to 120 grains), given slowly; subsequent doses, 3 or 4 gm. every six hours. Change to oral dosage as soon as possible. Sodium bicarbonate, 3 grams every four hours, should be given throughout the course of sulfadiazine in order to prevent renal complications associated with crystaluria by providing an alkaline urine. Penicillin is ineffective in the treatment of plague. No therapeutic serum is available at present. Hot, wet applications to buboes may be helpful. Incision should be delayed until localization is complete in order to avoid blood stream infection.

31. Preventive Measures in Advance of Known Infection, in Areas Subject To Plague.

a. Immunization. All military personnel in occupied areas should be immunized with plague vaccine. The initial vaccination consists of two subcutaneous injections of plague vaccine with an interval of 7 to 10 days between injections. The first dose is 0.5 cc. and the second 1.0 cc. of vaccine.

b. Use of Insecticide Powder. Insecticide, powder, louse, DDT, 2 ounce can (QM Stock No. 51-I-173) will be provided for each man. Whenever clothing is changed, or at weekly intervals if the same clothing must be worn for a longer period, DDT powder should be applied to the underclothing and inner surfaces of shirt and trousers in order to insure freedom from fleas. Inspection of troops and quarters for fleas should be held every two weeks.

c. Rodent Control. Personnel of units in occupied areas (Par. 4c, Cir. 42, GHQ, AFPAC, 14 August 1945. "Control of Malaria and Insect-Borne Diseases") will be trained in flea and rodent control in accordance with Training Memorandum No. 2, GHQ, AFPAC, 14 August 1945. Surveys of unit areas and necessary flea and rat eradication programs should be initiated by all unit commanders. In cities, especially ports, of each occupied area a systematic, continuous sampling survey of rats will be carried on by live trapping. The flea index of the rats will be noted, and the rats examined for evidence of plague. Any rats found dead will be collected and examined for plague.

d. Medical Intelligence. Close liaison should be maintained by unit surgeons with local military government and civilian public health authorities to assure early information of the presence of plague.

e. Supply. Timely requisition must be made of essential plague control supplies: rodenticides, traps, insecticides and bulk dimethylphthalate.

32. Control Measures - First Appearance Of Plague In Occupied Area.

a. Diagnosis. It is important to recognize sporadic cases. This diagnosis should be suspected on epidemiological grounds and confirmed by specific laboratory procedures. (See Par. 3 above).

b. Isolation of Patients. An isolation hospital for civilian cases should be established. Patients should be kept in separate screened rooms and only attendants allowed to enter. Attendants of pneumonic or suspected pneumonic cases must wear hoods with goggles or plastic eye openings, coveralls or complete gown with trousers, and rubber gloves. All waste articles contaminated by discharges are burned. Bedding, linens and utensils in contact with the patient should be sterilized by boiling or autoclaving. When a room is vacated the walls, floor and furniture should be disinfected by washing with 5 percent solution of compound cresol and the room allowed to air for 48 hours. Persons handling the bodies of patients who have died of plague should observe strict isolation technique.

c. Area Quarantine.

- (1) Civilian communities where an infection has occurred or may have occurred should be placed off limits to troops until the danger is past. An armed traffic patrol should be placed on all roads passing through the infected community to enforce the off limits regulation and to assure that civilians necessarily entering the infected area are disinfested with insecticide powder prior to entry and on exit therefrom. Provision for such disinfection should be maintained at road blocks. Military personnel entering or leaving an infected area on essential military duty should be disinfested by dusting with DDT powder. The common tendency of inhabitants of a plague infected town to flee to the country or to neighboring villages must be curbed, forcibly if necessary. Incubating the disease or carrying infected fleas, these refugees tend to spread the disease widely.
- (2) Contacts and suspected contacts of a patient with pneumonic plague should be disinfested and segregated. Their temperatures should be taken every 12 hours for ten days, and any such person developing fever should be isolated, regardless of the apparent cause of fever. Close contact with segregated persons should be avoided. Inspecting personnel must wear gowns, coveralls, caps, masks and rubber gloves, and should be dusted daily with insecticide powder.

d. Foreign Quarantine.

- (1) Personnel departing from plague areas should be certified as free from plague infection, and the statement made that their clothing and equipment are vermin free. Procedures necessary to give assurance of their condition, including inspection and delousing when indicated, should be carried out within 48 hours prior to departure.

- (2) Vessels having contact with ports in plague areas should be protected against the entry of rats. This may be accomplished by use of rat-free wharves, by lighterage, or by fending off from wharves. If a vessel is laid alongside a wharf there must be adequate rat-guards on all lines, and policing of cargo nets and gang planks. At night, nets and gang planks should be lighted brilliantly.
- (3) Steps should be taken to assure that cargo taken on is free from rats.
- (4) Rat trapping should be continuous on vessels, especially those having contact with plague ports. Vessels should be subjected to inspection and/or fumigation by quarantine authorities at the non-plague port of entry.

e. **Flea Control.** Control of plague in a civilian community is based upon the premise that the plague infected flea is the primary agent in transmitting the disease to man, the rat being of secondary importance as the source of infection for the flea.

- (1) **Focal disinfection.** It is wasteful of effort and efficiency to attempt to rid entire towns or cities of fleas. The attack should center about known infected foci, houses or buildings where cases of plague have developed. Having described a circle with a radius of 100 yards from the focal point all persons and things within that area, starting peripherally and working toward the center, should be disinfested. Persons should be thoroughly dusted with DDT powder as described in Circular Letter 44, Office Of The Chief Surgeon, GHQ, AFPAC, dated 26 October 1945, par 2d and 3c. Pets and domestic animals should be thoroughly dusted with DDT powder. Clothing, bedding and furniture should be thoroughly dusted. Walls, ceilings and floors are to be sprayed with DDT residual spray, making sure that any cracks receive especial attention. Rat runs should be heavily powdered with DDT dust and it should be blown down rat holes and into rat harborages. For dusting, as described above, either QM Item No. 51-I-180 or 51-L-122 may be used, applied at the rate of 1 lb. per sq. ft. of flat surface. Insecticide, spray, DDT, residual effect (QM Item No. 51-I-305) should be applied at the rate of 1 quart per 250 sq. ft.
- (2) **Other measures indicated.** Rat trapping lines should be run radially beyond the focal zone. If plague rats or rats with a high flea index are discovered the disinfection process should be repeated, again proceeding inward from the outermost point of suspected infestation. Military and civilian personnel engaged in plague control should apply insect repellent to exposed skin in the manner prescribed for mosquitoes. While repellents do not prevent fleas from alighting, the fleas leave the treated surface almost immediately and do not bite. Clothing, including socks, should be impregnated with dimethylphthalat

QM Item No. 51-R-300, Repellent, insect, clothing treatment, or QM Item No. 51-R-265, Repellent, insect, 2 oz. bottle. (If the 2 ounce bottle of insect repellent is used, care must be taken that the particular issue is pure dimethylphthalate, since this item number includes also indalone, Formula 612, and 6-6-2 mixture, which are not as effective.) It is important that trousers should be tucked into boots and leggings. Military personnel within or adjacent to a plague infected area should be disinfested weekly with 10% DDT powder applied by hand or power duster.

Hospitals, barracks, mess halls and storerooms of military installations within or adjacent to a plague infected area should be kept free of fleas by use of DDT powder or residual spray. Rat harborages should receive special attention.

f. Rodent Control. When human plague is discovered, the extent of the disease in the rodent population should be determined by trapping in every direction from the focus of infection until no additional infected animals are found. As soon as focal disinfection is complete a rat extermination program should be instituted, again working from the periphery toward the point of infection. Rats should be killed by trapping, poisoning and fumigation, buildings and ships should be rat-proofed, rat harborages should be destroyed, and trash piles cleaned up. Food supplies should be carefully protected against the access of rats, and attention given to the collection and disposal of garbage.

g. Immunization. All American military personnel within the general area of infection should receive a stimulating dose of 1.0 cc of plague vaccine.

h. Natives on Military Posts. Natives from a town or village where cases of plague are occurring should not be admitted within army unit areas. The number of natives employed within the military installation should be reduced to a minimum, and they should be required to live on the post. If this is impractical, they and their quarters should be disinfested, and signs of febrile illness sought for each day when they report for duty. Such personnel should be immunized against plague.

32. Control of Plague - Declared Epidemic. Full use should be made of Army or Corps case finding teams if available. (Those will normally consist of one Medical Corps Officer and two enlisted men, including one NCO trained in clinical and laboratory diagnosis. They are set up to insure the early detection of civilian cases.) Disinfection and rodent control teams are provided for in Par. 4b (2), Circular No. 42, GHQ, AFPAC, 14 August 1945, and will be composed of especially trained Malaria Control personnel.

a. Operation of Epidemic Case Finding Teams.

- (1) Make epidemiologic case studies of all reported cases of plague or suspected plague, with special attention toward determining sources of infection and identification of contacts.

- (2) Initiate preliminary and emergency control measures in each case of suspected or confirmed plague, to include action for removal of patient to hospital, disinfection of patient and immediate contacts, and of the patients' immediate environment.
- (3) Organize and augment house to house case finding in the infected community, using civilian personnel to the fullest extent.
- (4) Assure immunization and disinfection of all civilian personnel engaged in plague control.
- (5) Consult and aid in provision of adequate isolation measures for patients in civilian hospitals.

b. Operation of Disinfestation and Rodent Control Teams.

- (1) Disinfest all buildings and the people inhabiting them within a 100 yard radius from a house in which plague is reported.
- (2) Survey the infected community and immediate surrounding area for rodent population.
- (3) Direct and aid in carrying out a program for rat extermination in the infected community and in nearby military establishments.
- (4) Organize facilities for disinfection by dusting at road blocks outside infected communities.

XV. Clinical Manifestations In Serologically Proved Cases Of Japanese B Encephalitis In Military Personnel On Okinawa In 1945.

34. Following is an extract from report by Lt. Col. Albert B. Sabin, MC, AUS, Army Epidemiological Board, Surgeon Generals' Office:

a. The adjective "lethargica" commonly reserved for Ven Economo's (Type A) encephalitis is most applicable to the disease as it was seen in the American military personnel, in whom a positive diagnosis of Japanese B encephalitis virus infection was ultimately established by serological methods. Drowsiness, lethargy, mental confusion and disorientation, and semi-coma or complete coma in the more severe cases, occurring in association with high fever, nuchal and spinal rigidity, leucocytosis and pleocytosis constituted the most important manifestations for diagnostic purposes. The onset was usually sudden with fever and very severe headache, although the mental confusion and lethargy, and even the stiffness of the neck and spine, the latter easily demonstrated by the kiss-the-knee test, frequently did not appear until several days later. Actual paralysis was seen only once in this group of patients and that in a case with early fatal termination. True convulsions were also seen only in the two fatal cases. Dissociated eye movements which were not infrequently seen in the native children with the disease were observed in only one patient, again with fatal termination. The pupils, however, were usually contracted and reacted poorly to light. Diplopia did not occur in this

group. A milky, sticky exudate was often seen about the eyes. Athetosis, incoordination and tremor of the hands were not uncommon and difficulty in writing could be easily demonstrated. Difficulties in speech ranged from slurring to complete aphasia. The reflexes were variable. The abdominals were usually absent, while the tendon reflexes were most often exaggerated, although occasionally they might become diminished or disappear. Positive Babinski's were uncommon.

b. The fever was high and lasted 7 to 11 days except in one patient who also developed a bronchopneumonia. A relative bradycardia was invariably present during the febrile phase, and a pulse rate of 50 to 60 was common after defervescence. A leukocytosis in the range of 10,000 to 25,000 with a definite increase in the number of mature and immature neutrophiles was the rule in these patients, and was also found regularly in the native cases by Lt. John W. Norcross (MC) USNR. The cerebrospinal fluid was clear, under normal or slightly increased pressure, and pleocytosis, ranging from 22 to 660 white cells per cu. mm. in the first specimen examined, was present in all patients of this group. The cells were predominately mononuclear, although in one acutely ill patient most of the 400 cells seen on the third day of the disease were reported as polymorphonuclear. The protein was normal or slightly increased early in the disease, while during convalescence a 3 or 4 plus Pan's reaction was not uncommon. Pellicle formation was observed in at least one patient on the fifth day of the disease.

c. Convalescence was slow and lethargy, incoordination, tremors and "nervousness" usually persisted for weeks after defervescence. The condition of at least one patient was still rated as poor seven weeks after onset, with mask-like facies, somnolence, hyperirritability, and distinct personality change manifested by stoic, perverse obstinacy, moroseness, disinclination to talk, urinating on the floor of the ward, etc.

XVI. New Film On Psychiatry.

35. Attention is invited to a new film on psychiatry which is now or will be available at film exchanges. The following paragraphs of description are extracted from a letter, Army Service Forces, Signal Corps Photographic Center, 30 April 1946, subject: "Initial Distribution of Misc. 1241, LET THERE BE LIGHT":

a. Subject film is an authentic pictorial record of approximately a score of cases of servicemen who were victims of psychiatric disorders. Following their transfer from aboard ship to a large modern Army general hospital each case is interviewed by a psychiatrist, a diagnosis made and treatment started. Cases include paralysis of legs, amnesia, loss of speech, tremors and other types of disorders. Treatments include hypnosis and shock therapy. The microphone and the camera closeups add to the realism of the case histories. Various types of handicraft activities develop further confidence in the individual. Social reorientation as well as physical, mental and educational reconditioning are accomplished through individuals relating their personal problems in group discussions, lectures, simple games and later more vigorous athletic activities and sports.

b. Distribution of subject film is being made in accordance with recommendations from the Office of The Surgeon General. Neuropsychiatry Consultants Division, OSG, has advised that:

"The following instructions should be issued by letter to each recipient of the film at the time of its release. These instructions also should be printed on a label pasted on to the film containers:

"This film is intended for showing to professional groups who have responsibility for the treatment and personal adjustment of individuals suffering from psychiatric disorders, particularly, exservicemen. Protection of the individual rights and rights of privacy of the patients appearing in the film must be guaranteed by the professional ethics of the groups to whom it is made available. The War Department releases this film only with the explicit understanding that it will not be shown to persons not bound by professional medical ethics."

c. Neuropsychiatry Consultants Division, Office of the Surgeon General, has further advised that subject film should be made available for showing to all commissioned Army personnel and utilized in the training of such enlisted personnel as are responsible for or participating in the treatment of neuropsychiatric cases.

XVII. Treatment Of Thoracic Wounds.

36. The treatment of chest wounds is directly concerned with measures to restore a sudden disturbance in cardio-respiratory physiology, and to control hemorrhage, having in mind at all times the prevention of infection, and the prevention of the formation of organizing massive blood clots which will prohibit later expansion of the lung.

37. The three common chest wound emergencies are the sucking wound, tension pneumothorax, and hemorrhage.

a. Sucking wounds. Ideally, these wounds should be closed immediately. When this cannot be done, occlusive dressings, preferably with vaseline gauze, may be used. These can be held in place either by a tight adhesive dressing, or by sutures.

b. Tension pneumothorax is indicated by signs of increasing dyspnoea, engorgement of the neck veins and developing cyanosis. A single or repeated aspiration of air will usually suffice in treatment, but occasionally, a short beveled needle of about 15 gauge must be inserted into the 2d or 3d interspace anteriorly, and left in place with a tube attached leading to an underwater seal, or to a finger cot flutter-valve.

c. Hemorrhage.

(1) Hemothorax is an almost invariable complication of gunshot or shrapnel wounds of the chest, and it frequently occurs as a result of direct trauma to the chest wall without penetration. The bleeding is usually from the intercostal vessels, less frequently from vessels within the lung, and still less frequently from other structures within the thoracic cage. Unless the amount of parenchmal damage is great, the bleeding is relatively slow. Bleeding from the intercostal or internal mammary vessels usually leads to the rapid development of hemothorax, and this type of bleeding may be continuous.

(2) The treatment of hemothorax has been a subject of some controversy. Recent experience, however, has led to the establishment of certain principles which are here set forth.

(a) **Aspiration.** Early and repeated aspiration of blood without air replacement is essential in the proper management of hemothorax.

1. Immediate aspiration may be necessary to obtain relief when the quantity of blood within the thorax is so great that the lung has been crowded and the mediastinum displaced to a point where either respiratory or cardiovascular embarrassment has occurred.
2. Even in the absence of signs of such embarrassment, aspiration should be made within 12 to 24 hours after injury, and repeated as soon as more blood accumulates, even though this may be within a few hours, because of the following reasons:
 - a. Repeated aspiration gives an early index of the type of bleeding and the rapidity with which hemothorax is occurring. This is important to know, as it early determines whether the bleeding can be handled by conservative therapy, or whether a more radical operative procedure will be necessary.
 - b. The sooner a collapsed lung is re-expanded, the easier and more certain the re-expansion will be.
 - c. The removal of blood will prevent the organization of deposited fibrin on the pleural surfaces. If such organization is permitted, fibrothorax, with restricted respiratory excursions, will be the result.
 - d. Aspiration of blood may prevent empyema or limit the extent of an empyema if it does occur. Accumulated blood is a good nidus for bacterial growth, and the larger the quantity of blood, the more extensive will be the empyema.
3. The urgency of aspiration is dictated by evidences of circulatory or respiratory embarrassment. Subsidence of acute symptoms is often obtained only by repeated aspirations, but it may be, in instances where bleeding is relatively slight, arrived at spontaneously. Even though the effusion is too small to produce symptoms, the blood should, nevertheless, be removed after

24 to 48 hours for the reasons stated above.

4. Transfusion is a necessary adjunct to aspiration, and matched blood should be available at the time of aspiration. The amount and frequency of transfusions can be determined by condition of the patient and amount of blood removed from pleural cavity.
5. Rarely in order to prevent recurrence of bleeding due to re-expansion of the lung it may be necessary to replace by air the blood which has been removed. Such air replacement, however, is not often necessary and seldom, if ever, after more than the first aspiration.
6. Penicillin. After each aspiration, 100,000 units of penicillin in solution should be injected into the pleural cavity.
7. Precautions. During aspiration, the patient's condition should be watched carefully, and if undue chest pain, rapid or irregular heart action, weakness or excessive sweating occur, the procedure should be discontinued. Preferably it should again be repeated within 12 hours, and certainly not later than 24 hours.
8. Technique of aspiration. Aspiration of the chest while relatively simple surgical procedure, unless done properly, can lead to such serious complications as phlegmon of the chest wall, infection of the hemothorax and empyema. It is advised that the following technique be followed:
 - a. The choice of site for aspiration is important. Frequently, in simple bleeding into a pleural cavity, the blood will remain in a thin, fluid state for extended periods of time and can be withdrawn with an ordinary, long, thin needle. Such fluid blood, when not localized, is best removed through the lower intercostal spaces, posterior axillary line. The posterior axillary line allows for tubal drainage, if the fluid is found to be infected or even clotted, and if irrigation is required, without the tube becoming kinked if the patient is confined to bed.
 - b. The area through which aspiration is to be made should be properly shaved, and carefully prepared with soap and water, alcohol and tincture of merthiolate. The area should be

properly anesthetized with local novacain, and the anesthetic given time to take effect. It may be necessary, in the course of aspiration to use a larger gauge, #15, needle, for which it may be desirable to make a nick into the skin for easier introduction. After the needle is within the pleural cavity, one should guard against the danger of air escaping into the chest. This precaution may be handled by the use of a 3-way stop-cock, or, if one is not available, by use of a piece of plasma tubing attached to the butt of the needle. If no fluid is obtained at the first tap, one should try again in an interspace above or below, with sometimes even three or four attempts being necessary. If no blood is obtained after such an attempt, or if only a small amount of thick blood returns, one can be fairly certain that clotting has occurred.

(b) Thoractomy. The indications for thoractomy are:

1. Hemothorax due to active bleeding which persists following one or more aspirations. This bleeding is usually due to laceration of the intercostal or internal mammary vessels. More rarely, it is due to large lacerations of the lung parenchyma.
2. Early massive clotted hemothorax from whatever cause.
3. The presence of foreign bodies, 2 cm or larger, in the lung parenchyma or pleural cavity. Particularly important in this regard are shattered bone fragments. These latter may become necrotic and form the nidus of infection.
4. Wounds of large bronchi or the intrathoracic portion of the trachea are repaired through a thoractomy incision. Such wounds usually cause a continuous pneumothorax and when not properly aspirated tension pneumothorax develops and persists.
5. A large sucking wound.

38. Later complications in chest wounds include residual "clotted hemothorax", infected hemothorax and empyema. These complications must be treated only by thoracic surgeons, or by general surgeons experienced in thoracic surgery. Patients with chest injuries should, therefore, be evacuated to general hospitals within the theater just as soon as these patients can be safely transported. This can usually be done from within 3 to 10 days after injury.

a. Clotted hemothorax. This should be suspected when clinical and X-Ray findings persist, and only small amounts of blood can be withdrawn through a large needle. As soon as such a diagnosis is made, thoracotomy should be undertaken as early as the patients' condition allows. The reasons for early thoracotomy are that

- (1) Once the hemothorax begins to organize, the process is irreversible and almost never clears spontaneously.
- (2) As this organization progresses, the operative procedure of decortication becomes more and more difficult since any cleavage planes become obliterated.
- (3) The longer a lung is collapsed and compressed, the more difficult re-expansion becomes. The best results of decortication have been obtained when this has been done within the first 10 days following injury.

b. Empyema. Empyema complicating hemothorax demands prompt surgical intervention by tidal drainage or rib resection, or, when response from these methods of treatment is delayed and when the patients' condition permits, radical thoracotomy with the evacuation of residual clots and decortication of the lung. The latter procedure should be performed as early as possible, because the surgical line of cleavage becomes obliterated after this time by organization of inflammatory exudate. Systemic and local penicillin is used as an adjuvant.

39. Other important measures in the treatment of chest wounds are:

a. Bronchoscopic or catheter aspiration of blood and mucus from the tracheo-bronchial tree. This is a very important factor in preventing post-operative atelectasis and pneumonia. Ideally, every patient who undergoes thoracotomy should be bronchoscoped before leaving the operating table and the procedure should be repeated as often thereafter as indicated.

b. Infiltration of the intercostal nerves with procaine hydrochloride solution for relief of chest wall pain. This enables the patient to cough effectively and clear the air passages of blood secretions.

c. Endotracheal oxygen-ether, administered through a closed apparatus capable of maintaining positive pressure, is the form of anesthesia indicated in the operative management of penetrating and perforating chest wounds.

XVIII. Definition Of Emergency Hospital Care.

39. There will shortly be issued from this headquarters, command publications which will amplify the conditions and procedures for emergency treatment and hospitalization by United States Army Medical Installations of miscellaneous categories of civilians not authorized treatment at government expense. The basic policy announced by the War Department has defined emergency treatment and hospitalization as that which is authorized by paragraph 6 ad Army Regulations 40-590. However, these publications will require a very liberal interpretation of the term "emergency care". They will point out that in many areas in the Pacific, civilian medical facilities do not exist and in others is entirely inadequate for care of native populations. Therefore, a high or minimum of treatment and hospitalization must be set for miscellaneous civilians, other than enemy nationals, than would be required in Zone of Interior or in Hawaii.

Evacuation XIX
 Hospitalization XX

XIX. Evacuation

40. a. During the month of April the following patients were evacuated from the several major commands:

	AIR	WATER	TOTAL
EIGHTH ARMY	150	273	423
AFMIDPAC	60	38	98
AFWESPAc	74	919	993
XXIV CORPS	(unclassified)		130

b. The following are the evacuations per 1000 strength for the month of April:

JAPAN	2.36%
KOREA	2.92%
AFMIDPAC	2.26%
AFWESPAc	5.90%
AFPAC	3.73%

c. As of 30 April 1946 the following number of patients were awaiting evacuation:

EIGHTH ARMY	282
AFMIDPAC	28
AFWESPAc	200
XXIV CORPS	52

XX. Hospitalization

41. a. The Bed Status Report of 30 April is as follows:

	TOTAL T/O BEDS PRESENT	TOTAL T/O BEDS ESTABLISHED	TOTAL T/O BEDS OCCUPIED
EIGHTH ARMY	9950	5588	3697
AFMIDPAC	6525	2375	1079
AFWESPAc	7475	4544	2901
XXIV CORPS	3300	1584	1085
Total	27,250	14,091	8,762

b. Number of authorized beds, percent of authorized beds occupied, percent of operating beds occupied and percent of actual military strength in hospitals as patients are listed below:

BEDS AUTHORIZED	% AUTHORIZED BEDS OCCUPIED	% OPERATING BEDS OCCUPIED*	TOTAL PATIENTS IN HOSPITAL, % OF ACTUAL MILITARY STRENGTH
JAPAN	8,383	45%	69% 2.12%
KOREA	2,728	39%	68% 2.09%
AFMIDPAC	3,940	28%	46% 2.85%
AFWESPAc	6,668	42%	59% 1.59%
AFPAC	21,626	40%	62% 1.99%

*The low percentage of authorized beds occupied reflects the fact that

the actual strength of the theater during April was only approximately 61% of the authorized strength.

c. The following tables from "A" to "M" show the admission rates for the current year.

ADMISSION RATES PER 1000 PER ANNUMALL CAUSES

<u>Week Ending</u>	<u>AFPIIC</u>	<u>AFMIDPAC</u>	<u>AFWESPAC</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 1946	660	340	556	862	483
11 Jan 1946	735	380	611	1067	504
18 Jan 1946	812	355	666	922	683
25 Jan 1946	726	343	661	998	610
1 Feb 1946	683	395	574	979	496
8 Feb 1946	768	629	591	973	670
15 Feb 1946		511	*	947	716
22 Feb 1946		319	*	966	707
1 Mar 1946		187	*	1005	637
8 Mar 1946		354	*	1099	578
15 Mar 1946		264	*	1103	688
22 Mar 1946		278	*	961	872
29 Mar 1946		323	*	978	768
5 Apr 1946		298	*	938	760
12 Apr 1946		343	*	851	677
19 Apr 1946		251	*	*	*

* Report Not Yet Received.

ADMISSION RATES PER 1000 PER ANNUM

MYCOTIC DERMATOSES

Week Ending	AFPAC	AFMIDPAC	AFNESPAC	JAPAN	KOREA
4 Jan 46	2.7	.4	11.0	16	3.3
11 Jan 46	8.2	0	9.9	11	1.7
18 Jan 46	7.6	.6	10.1	9.5	1.9
25 Jan 46	10.6	0	13.7	11	0
1 Feb 46	9.7	0	10.0	13	3.0
3 Feb 46	17.6	1.5	34.5	11	0
15 Feb 46		0	*	13	4.5
22 Feb 46		0	*	8	3.5
1 Mar 46		0	*	9.1	3.1
8 Mar 46		1.2	*	10.4	3.9
15 Mar 46		0	*	10.4	2.2
22 Mar 46		0	*	12.7	1.0
29 Mar 46		0	*	12.5	4.0
5 Apr 46		0	*	11.6	0
12 Apr 46		0	*	10.4	0
19 Apr 46		4.3	*	*	*

*Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

VENereal DISEASES

<u>Week Ending</u>	<u>AFPAC</u>	<u>AFMIDPAC</u>	<u>AF.ESPAC</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 46	131	8	112	231	13
11 Jan 46	144	17	146	226	20
13 Jan 46	147	5	143	245	15
25 Jan 46	151	21	131	263	13
1 Feb 46	115	6	93	214	20
3 Feb 46	139	16	133	223	51
15 Feb 46		8	*	236	56
22 Feb 46		7	*	275	52
1 Mar 46		6	*	239	42
3 Mar 46		20	*	268	37
15 Mar 46		3	*	242	43
22 Mar 46		15	*	229	55
29 Mar 46		18	*	232	42
5 Apr 46		12	*	203	31
12 Apr 46		25	*	164	46
19 Apr 46		31	*	*	*

* Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

MALARIA

<u>Week</u> <u>Ending</u>	<u>AFPAC</u>	<u>AFNIDPAC</u>	<u>AF.ESPAC</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 46	44	1.5	37	79	47
11 Jan 46	38	0	28	69	32
18 Jan 46	39	.6	31	72	24
25 Jan 46	33	.7	23	60	23
1 Feb 46	42	.7	29	50	14
8 Feb 46	38	0	34	62	35
15 Feb 46		0	*	42	52
22 Feb 46		1.0	*	43	40
1 Mar 46		6.2	*	45	36
8 Mar 46		1.2	*	55	41
15 Mar 46		13.9	*	43	50
22 Mar 46		1.4	*	46	66
29 Mar 46		8.3	*	45	40
5 Apr 46		2.7	*	47	45
12 Apr 46		2.9	*	42	31
19 Apr 46		5.7	*	*	*

* Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

DYSENTERY, AMEBIC

<u>Week Ending</u>	<u>AFPAC</u>	<u>AFMIDPAC</u>	<u>AFLESPAC</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 46	1.4	0	1.7	1.4	2.5
11 Jan 46	1.7	0	2.4	.9	3.5
18 Jan 46	2.1	0	2.7	2.1	3.9
25 Jan 46	3.9	0	6.4	3.7	2.9
1 Feb 46	3.6	0	5.2	3.7	0
8 Feb 46	3.2	0	5.3	2.2	4.4
15 Feb 46		0	*	3.8	1.1
22 Feb 46		0	*	2.5	0
1 Mar 46		0	*	1.1	0
3 Mar 46		0	*	0.6	7
15 Mar 46		2.6	*	0.6	2.2
22 Mar 46		1.4	*	0.8	3.1
29 Mar 46		0	*	1.2	2.0
5 Apr 46		0	*	0.3	2.0
12 Apr 46		1.5	*	0	1
19 Apr 46		0	*	*	*

*Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

BACILLARY DYSENTERY

<u>Week Ending</u>	<u>AFPAC</u>	<u>AFMIDPAC</u>	<u>AFWESPAC</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 46	.4	0	.6	0	1.7
11 Jan 46	1.2	0	2.6	.9	.9
18 Jan 46	4.9	0	12.4	.2	0
25 Jan 46	1.2	0	2.9	.2	0
1 Feb 46	1.0	0	2.4	.3	0
8 Feb 46	1.4	0	3.5	0	0
15 Feb 46		0	*	0	2.2
22 Feb 46		0	*	0	0
1 Mar 46		0	*	.3	0
8 Mar 46		0	*	0	0
15 Mar 46		0	*	0	0
22 Mar 46		0	*	0	1.0
29 Mar 46		0	*	0	0
5 Apr 46		0	*	0	0
12 Apr 46		0	*	0	0
19 Apr 46		0	*	*	*

* Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

COMMON DIARRHEA

<u>Week Ending</u>	<u>AFPAC</u>	<u>AFMIDPAC</u>	<u>AFWESPAC</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 46	13	2.1	25	7.2	0
11 Jan 46	14	3.4	26	8.2	1.7
18 Jan 46	13	24	22	7.6	1.9
25 Jan 46	12	10	23	3.5	0
1 Feb 46	9	2.1	18	4.6	0
8 Feb 46	9	1.2	16	3.8	0
15 Feb 46		0	*	7.0	0
22 Feb 46		0	*	5.3	0
1 Mar 46		0	*	2.9	0
8 Mar 46		1.2	*	5.8	3
15 Mar 46		0	*	7.9	0
22 Mar 46		0	*	3.6	0
29 Mar 46		0	*	4.1	2
5 Apr 46		1.4	*	5.1	1
12 Apr 46		0	*	6.2	1
19 Apr 46		0	*	*	*

*Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

PNEUMONIA, PRIMARY, ATYPICAL

<u>Week Ending</u>	<u>AFPAC</u>	<u>AFMIDPAC</u>	<u>AFWESPAC</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 46	5.6	3.6	8.2	3.9	8.3
11 Jan 46	7.7	6.9	9.3	6.5	10
18 Jan 46	10.0	6.2	12.4	12.0	6.8
25 Jan 46	9.2	4.0	13.5	8.9	9.7
1 Feb 46	7.1	6.2	3.3	8.3	4.8
8 Feb 46	10.5	1.5	4.3	11.0	17
15 Feb 46		2.7	*	4.3	8.8
22 Feb 46		1.0	*	10.0	4.4
1 Mar 46		1.0	*	8.3	8.0
8 Mar 46		1.2	*	5.5	12
15 Mar 46		1.3	*	4.8	7
22 Mar 46		5.5	*	3.6	11
29 Mar 46		5.5	*	4.9	11
5 Apr 46		5.5	*	6.2	12
12 Apr 46		2.9	*	3.5	8
19 Apr 46		4.3	*	*	*

*Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

INFLUENZA

<u>Week Ending</u>	<u>AFPAC</u>	<u>AFMIDPAC</u>	<u>AFWESPA</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 1946	5.3	1	4.9	3.5	.8
11 Jan 1946	2.4	.6	4.2	2.2	.9
18 Jan 1946	1.9	1.9	2.5	1.9	0
25 Jan 1946	3.3	0	7.7	.5	0
1 Feb 1946	15.1	101	3.9	4	1.9
8 Feb 1946	8.6	48	1.2	5.5	1.1
15 Feb 1946		20	*	4.3	1.1
22 Feb 1946		7	*	4.4	0
1 Mar 1946		2.0	*	3.7	0
8 Mar 1946		1.2	*	2.0	0
15 Mar 1946		0	*	4.6	0
22 Mar 1946		2.8	*	1.7	5.2
29 Mar 1946		1.4	*	.9	0
5 Apr 1946		0	*	.9	0
12 Apr 1946		0	*	3.2	*
19 Apr 1946		1.4	*	*	*

*Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

COMMON RESPIRATORY DISEASES

Week Ending	AFRIC	AFRIDRIC	AFRESRIC	JPN	KORE
1 Jan 46	101	23	65	173	59
11 Jan 46	113	58	66	191	105
12 Jan 46	105	78	65	173	63
22 Jan 46	111	74	65	195	43
1 Feb 46	91	43	60	165	36
8 Feb 46	124	234	74	160	52
15 Feb 46	-	104	*	148	75
22 Feb 46	-	70	*	162	72
1 Mar 46	-	20	*	178	106
8 Mar 46	-	27	*	182	70
15 Mar 46	-	28	*	214	77
22 Mar 46	-	24	*	218	133
29 Mar 46	-	21	*	236	133
5 Apr 46	-	22	*	183	91
12 Apr 46	-	25	*	165	102
19 Apr 46	-	30	*	*	*

*Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

INJURY

<u>Week Ending</u>	<u>AFPAC</u>	<u>AFMIDPAC</u>	<u>AFWESPAC</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 46	76	73	79	76	54
11 Jan 46	82	92	77	94	75
18 Jan 46	83	62	83	91	104
25 Jan 46	77	80	99	80	91
1 Feb 46	76	56	73	89	77
8 Feb 46	74	45	68	84	88
15 Feb 46		37	*	37	92
22 Feb 46		49	*	83	73
1 Mar 46		22	*	71	75
8 Mar 46		61	*	81	66
15 Mar 46		38	*	76	82
22 Mar 46		43	*	72	66
29 Mar 46		35	*	91	57
5 Apr 46		60	*	90	78
12 Apr 46		79	*	65	65
19 Apr 46		61	*	*	*

*Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

DISEASES

<u>Week Ending</u>	<u>AFPAC</u>	<u>AFMIDPAC</u>	<u>AFWESPACE</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 46	584	267	477	786	429
11 Jan 46	653	288	534	973	429
18 Jan 46	729	293	583	831	579
25 Jan 46	649	263	562	918	519
1 Feb 46	607	339	501	890	419
8 Feb 46	694	584	523	889	582
15 Feb 46		474	*	859	624
22 Feb 46		270	*	884	634
1 Mar 46		165	*	934	562
8 Mar 46		293	*	1018	512
15 Mar 46		226	*	1027	606
22 Mar 46		235	*	889	806
29 Mar 46		268	*	827	711
5 Apr 46		238	*	848	682
12 Apr 46		264	*	786	613
19 Apr 46		297	*	*	*

* Report not yet received.

ADMISSION RATES PER 1000 PER ANNUM

INFECTIOUS HEPATITIS

<u>Week Ending</u>	<u>AFPAC</u>	<u>AFMIDPAC</u>	<u>AFWESPAC</u>	<u>JAPAN</u>	<u>KOREA</u>
4 Jan 46	8.1	1.0	10	10	6.7
11 Jan 46	7.6	1.7	9.7	9.5	4.4
18 Jan 46	8.4	.6	9.5	7.3	4.8
25 Jan 46	5.6	0	6.9	6.7	6.8
1 Feb 46		0	6.9	8.8	4.8
8 Feb 46		0	18	8.5	6.5
15 Feb 46		.9	*	10.0	11.0
22 Feb 46		0	*	18.0	4.4
1 Mar 46		1.0	*	10.0	2.2
8 Mar 46		0	*	9.8	5.0
15 Mar 46		0	*	7.9	1.4
22 Mar 46		0	*	8.0	7.2
29 Mar 46		0	*	9.6	4.0
5 Apr 46		0	*	8.3	5.0
12 Apr 46		1.5	*	8.3	13
19 Apr 46		0	*	*	*

*Report not yet received.

Table "M"

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J. I. Martin
J. I. MARTIN
Brigadier General, USA
Chief Surgeon

